MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-03-8156-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address Cumis Insurance Society, Inc. Box 19	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: W614169

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/09/03	01/09/03	99358	$84.00	

PART III: REQUESTOR'S POSITION SUMMARY

Position Statement dated 06/16/03 states in part, "…Our charge for code 99358 "Prolonged physician service without direct face to face" was denied as code F (Fee Schedule). We had resubmitted this charge as this is a reimbursable charge per TWCC MFG; however, our request for reconsideration was denied. We feel that this should be reimbursed by the carrier as our documentation supports this charge and is within the criteria of TWCC MFG."

PART IV: RESPONDENT'S POSITION SUMMARY

Position Statement dated 07/19/03 states in part, "…This dispute concerns DOS 1/9/2003, CPT code 99358, a charge for prolonged evaluation and management before or after direct patient care. The Carrier disputed these charges because they are inappropriately billed. First, the Carrier's position is that the service in included in another service performed on the same date. In addition, the Carrier's position is that the provider did not provide services in accordance with the definition of the CPT code, nor did the provider accurately document these services…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per the 1996 Medical Fee Guideline, Evaluation & Management Ground Rule (IV)(C)(a)(ii), and the CPT Descriptor, the submitted clinical report supports the services were rendered as billed. The 1996 Medical Fee Guideline, Surgery Ground Rule (I)(A)(1) the concept of a global fee is used for surgical procedures. Reimbursement in the amount of $84.00 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
1/9/2003	99358	$84.00	$84.00				
				Total Left Column:			$84.00
				Total Amount Due:			$84.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $84.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	12/10/04 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____